General

Guideline Title

Delirium, dementia, and depression in older adults: assessment and care.

Bibliographic Source(s)

Registered Nurses' Association of Ontario (RNAO). Delirium, dementia, and depression in older adults: assessment and care. Toronto (ON): Registered Nurses' Association of Ontario (RNAO); 2016 Jul. 156 p. [184 references]

Guideline Status

This is the current release of the guideline.

This guideline updates previous versions: Registered Nurses' Association of Ontario (RNAO). Screening for delirium, dementia and depression in older adults 2010 supplement. Toronto (ON): Registered Nurses' Association of Ontario (RNAO); 2010 May. 24 p. [76 references]

Registered Nurses' Association of Ontario (RNAO). Screening for delirium, dementia and depression in older adults. Toronto (ON): Registered Nurses' Association of Ontario (RNAO); 2003 Nov. 88 p. [53 references]

Registered Nurses' Association of Ontario (RNAO). Caregiving strategies for older adults with delirium, dementia and depression 2010 supplement. Toronto (ON): Registered Nurses' Association of Ontario (RNAO); 2010 May. 36 p. [174 references]

Registered Nurses' Association of Ontario (RNAO). Caregiving strategies for older adults with delirium, dementia and depression. Toronto (ON): Registered Nurses' Association of Ontario (RNAO); 2004 Jun. 181 p. [247 references]

This guideline meets NGC's 2013 (revised) inclusion criteria.

Regulatory Alert

FDA Warning/Regulatory Alert

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- May 10, 2016 – Olanzapine : The U.S. Food and Drug Administration (FDA) is warning that the antipsychotic medicine olanzapine can cause a rare but serious skin reaction that can progress to affect other parts of the body. FDA is adding a new warning to the drug labels for all olanzapine-containing products that describes this severe condition known as Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS).
- May 3, 2016 – Aripiprazole (Abilify, Abilify Maintena, Aristada) : The U.S. Food and Drug Administration (FDA) is warning that compulsive or uncontrollable urges to gamble, binge eat, shop, and have sex have been reported with the use of the

antipsychotic drug aripiprazole (Abilify, Abilify Maintena, Aristada, and generics). These uncontrollable urges were reported to have stopped when the medicine was discontinued or the dose was reduced. These impulse-control problems are rare, but they may result in harm to the patient and others if not recognized.

Recommendations

Major Recommendations

Definitions for the levels of evidence (Ia, Ib, IIa, IIb, III, IV, V) are provided at the end of the "Major Recommendations" field.

Practice Recommendations

Overarching Recommendations Related to Delirium, Dementia, and Depression

General Recommendations

Recommendation 1.1

Establish therapeutic relationships and provide culturally sensitive person- and family-centred care when caring for and providing education to people with delirium, dementia, and depression and their families and care partners.

(Levels of Evidence = Ia & V)

Recommendation 1.2

Identify and differentiate among signs and symptoms of delirium, dementia, and/or depression during assessments, observations, and interactions with older persons, paying close attention to concerns about changes expressed by the person, his/her family/care partners, and the interprofessional team.

(Level of Evidence = V)

Recommendation 1.3

Refer older adults suspected of delirium, dementia, and/or depression to the appropriate clinicians, teams, or services for further assessment, diagnosis, and/or follow-up care.

(Level of Evidence = Ia)

Recommendation 1.4a

Assess the person's ability to understand and appreciate information relevant to making decisions and, if concerns arise regarding the person's mental capacity, collaborate with other members of the health-care team as necessary.

(Level of Evidence = V)

Recommendation 1.4b

Support the older person's ability to make decisions in full or in part. If the older person is incapable of making certain decisions, engage the appropriate substitute decision-maker in decision-making, consent, and care planning.

(Level of Evidence = V)

Recommendation 1.5

Exercise caution in prescribing and administering medication to older adults (within the health-care provider's scope of practice), and diligently monitor and document medication use and effects, paying particular attention to medications with increased risk for older adults and polypharmacy.

(Level of Evidence = Ia)

Recommendation 1.6

Use principles of least restraint/restraint as a last resort when caring for older adults.

(Level of Evidence = V)

Recommendations Related to Delirium

Assessment

Recommendation 2.1

Assess older adults for delirium risk factors on initial contact and if there is a change in the person's condition.

(Levels of Evidence = Ia & V)

Planning

Recommendation 3.1

Develop a tailored, non-pharmacological, multi-component delirium prevention plan for persons at risk for delirium in collaboration with the person, his/her family/care partners, and the interprofessional team.

(Level of Evidence = Ia)

Implementation

Recommendation 4.1

Implement the delirium prevention plan in collaboration with the person, his/her family/care partners, and the interprofessional team.

(Level of Evidence = Ia)

Recommendation 4.2

Use clinical assessments and validated tools to assess older adults at risk for delirium at least daily (where appropriate) and whenever changes in the person's cognitive function, perception, physical function, or social behaviour are observed or reported.

(Levels of Evidence = Ia & V)

Recommendation 4.3

Continue to employ prevention strategies when caring for older adults at risk for delirium who have not been identified as having delirium.

(Levels of Evidence = Ia & V)

Recommendation 4.4

For older adults whose assessments indicate delirium, identify the underlying causes and contributing factors using clinical assessments and collaboration with the interprofessional team.

(Level of Evidence = Ia)

Recommendation 4.5

Implement tailored, multi-component interventions to actively manage the person's delirium in collaboration with the person, the person's family/care partners, and the interprofessional team *(Level of Evidence = Ia)*. These interventions should include:

- Treatment of the underlying causes *(Level of Evidence = Ia)*
- Non-pharmacological interventions *(Level of Evidence = V)*
- Appropriate use of medications to alleviate the symptoms of delirium and/or manage pain *(Level of Evidence = Ia)*

(Level of Evidence Ia & V)

Recommendation 4.6

Educate persons who are at risk for or are experiencing delirium and their families/care partners about delirium prevention and care.

(Level of Evidence = V)

Evaluation

Recommendation 5.1

Monitor older adults who are experiencing delirium for changes in symptoms at least daily using clinical assessments/observations and validated tools, and document the effectiveness of interventions.

(Level of Evidence = V)

Recommendations Related to Dementia

Assessment

Recommendation 6.1a

Assess older adults for possible dementia when changes in cognition, behaviour, mood, or function are observed or reported. Use validated, context-specific screening or assessment tools, and collaborate with the person, his/her family/ care partners, and the interprofessional team for a comprehensive assessment.

(Levels of Evidence = Ia & V)

Recommendation 6.1b

Refer the person for further assessment/diagnosis if dementia is suspected.

(Level of Evidence = Ia)

Recommendation 6.2

Assess the physical, functional, and psychological status of older adults with dementia or suspected dementia, and determine its impact on the person and his/her family/care partners using comprehensive assessments and/or standardized tools.

(Level of Evidence = V)

Recommendation 6.3

Systematically explore the underlying causes of any behavioural and psychological symptoms of dementia that are present, including identifying the person's unmet needs and potential "triggers." Use an appropriate tool and collaborate with the person, his/her family/care partners, and the interprofessional team.

(Level of Evidence = Ia)

Recommendation 6.4

Assess older adults with dementia for pain using a population-specific pain assessment tool.

(Level of Evidence = Ia)

Planning

Recommendation 7.1

Develop an individualized plan of care that addresses the behavioural and psychological symptoms of dementia (BPSD) and/or the person's personal care needs. Incorporate a range of non-pharmacological approaches, selected according to:

- The person's preferences
- The assessment of the BPSD
- The stage of dementia
- The person's needs during personal care and bathing
- Consultations with the person's family/care partners and the interprofessional team
- Ongoing observations of the person

(Level of Evidence Ia)

Implementation

Recommendation 8.1

Implement the plan of care in collaboration with the person, his/her family/care partners, and the interprofessional team.

(Level of Evidence = V)

Recommendation 8.2

Monitor older adults with dementia for pain, and implement pain-reduction measures to help manage behavioural and psychological symptoms of dementia.

(Levels of Evidence = Ia & V)

Recommendation 8.3

Employ communication strategies and techniques that demonstrate compassion, validate emotions, support dignity, and promote comprehension when caring for people with dementia.

(Level of Evidence = Ia)

Recommendation 8.4

Promote strategies for people living with dementia that will preserve their abilities and optimize their quality of life, including but not limited to:

- Exercise *(Level of Evidence = Ia)*
- Interventions that support cognitive function *(Level of Evidence = Ia)*
- Advanced care planning *(Level of Evidence = Ia)*
- Other strategies to support living well with dementia *(Level of Evidence = V)*

(Level of Evidence Ia & V)

Recommendation 8.5a

Provide education and psychosocial support to family members and care partners of people with dementia that align with the person's unique needs and the stage of dementia.

(Level of Evidence = Ia)

Recommendation 8.5b

Refer family members and care partners who are experiencing distress or depression to an appropriate health-care provider.

(Level of Evidence = V)

Evaluation

Recommendation 9.1

Evaluate the plan of care in collaboration with the person with dementia (as appropriate), his/her family/care partners, and the interprofessional team, and revise accordingly.

(Level of Evidence = V)

Recommendations Related to Depression

Assessment

Recommendation 10.1

Assess for depression during assessments and ongoing observations when risk factors or signs and symptoms of depression are present. Use validated, context-specific screening or assessment tools, and collaborate with the older adult, his/ her family/care partners, and the

interprofessional team.

(Levels of Evidence = Ia & V)

Recommendation 10.2

Assess for risk of suicide when depression is suspected or present.

(Level of Evidence = V)

Recommendation 10.3

Refer older adults suspected of depression for an in-depth assessment by a qualified health-care professional. Seek urgent medical attention for those at risk for suicide and ensure their immediate safety.

(Level of Evidence = V)

Planning

Recommendation 11.1

Develop an individualized plan of care for older adults with depression using a collaborative approach. Where applicable, consider the impact of co-morbid dementia.

(Levels of Evidence = Ia & V)

Implementation

Recommendation 12.1

Administer evidence-based pharmacological and/or non-pharmacological therapeutic interventions for depression that are tailored to the person's clinical profile and preferences.

(Levels of Evidence = Ia & V)

Recommendation 12.2

Educate older adults with depression (and their families/care partners, if appropriate) about depression, self-management, therapeutic interventions, safety, and follow-up care.

(Level of Evidence = V)

Evaluation

Recommendation 13.1

Monitor older adults who are experiencing depression for changes in symptoms and response to treatment using a collaborative approach. Document the effectiveness of interventions and changes in suicidal risk.

(Level of Evidence = V)

Education Recommendations

Education

Recommendation 14.1

All entry-level health-care programs include content and practice education opportunities that are specific to caring for older adults who have or are suspected of having delirium, dementia, and/or depression, and that are tailored to the discipline's scope of practice.

(Level of Evidence = V)

Recommendation 14.2

Organizations provide opportunities for nurses and other health-care providers to enhance their competency in caring for older adults with delirium,

dementia, and depression. Pertinent educational content should be provided during the orientation of new staff and students, and continuously through refresher courses and professional development opportunities.

(Levels of Evidence = Ia & V)

Recommendation 14.3

Design dynamic, evidence-based educational programs on delirium, dementia, and depression that support the transfer of knowledge and skills to the practice setting. Such programs should be:

- Interactive and multimodal *(Level of Evidence = Ia)*
- Interprofessional *(Level of Evidence = Ia)*
- Tailored to address learners' needs *(Level of Evidence = V)*
- Reinforced at the point of care by strategies and tools *(Level of Evidence = Ia)*
- Supported by trained champions or clinical experts *(Level of Evidence = Ia)*

(Level of Evidence Ia & V)

Recommendation 14.4

Evaluate educational programs on delirium, dementia, and depression to determine whether they meet desired outcomes, such as practice changes and improved health outcomes. Refine programs as required.

(Level of Evidence = V)

Organization and Policy

Organization and Policy

Recommendation 15.1

Organizations demonstrate leadership and maintain a commitment to foundational principles that support care for older adults with delirium, dementia, and depression, including:

- Person- and family-centred care *(Level of Evidence = Ia)*
- Collaborative, interprofessional care *(Level of Evidence = Ia)*
- Healthy work environments *(Level of Evidence = V)*

(Level of Evidence Ia & V)

Recommendation 15.2

Organizations select validated screening and assessment tools for delirium, dementia, and depression that are appropriate to the population and health-care setting, and provide training and infrastructure to support their application.

(Level of Evidence = V)

Recommendation 15.3

Organizations implement comprehensive, multi-component programs, delivered by collaborative teams within organizations, to address delirium, dementia, and depression *(Level of Evidence = Ia)*. These should be supported by:

- Comprehensive educational programs *(Level of Evidence = V)*
- Clinical experts and champions *(Level of Evidence = Ia)*
- Organizational processes that align with best practices *(Level of Evidence = V)*

(Level of Evidence Ia & V)

Recommendation 15.4

Establish processes within organizations to ensure that relevant information and care planning for older adults with delirium, dementia, and depression is communicated and coordinated over the course of treatment and during care transitions.

(Levels of Evidence = Ia & V)

Definitions

Levels of Evidence

Ia Evidence obtained from meta-analysis or systematic reviews of randomized controlled trials, and/or synthesis of multiple studies primarily of quantitative research.

Ib Evidence obtained from at least one randomized controlled trial.

IIa Evidence obtained from at least one well-designed controlled study without randomization.

IIb Evidence obtained from at least one other type of well-designed quasi-experimental study, without randomization.

III Synthesis of multiple studies primarily of qualitative research.

IV Evidence obtained from well-designed non-experimental observational studies, such as analytical studies or descriptive studies, and/or qualitative studies.

V Evidence obtained from expert opinion or committee reports, and/or clinical experiences of respected authorities.

Clinical Algorithm(s)

The following algorithms are available in the original guideline document:

- Flow Chart For Delirium, Dementia, and Depression
- Flow Chart For Delirium
- Flow Chart For Dementia
- Flow Chart For Depression

Scope

Disease/Condition(s)

Dementia, delirium, and depression

Note: The following conditions and topics are not covered within the scope of the guideline: delirium caused by alcohol withdrawal, delirium in the last days of life, early onset dementia (dementia occurring in middle age), and prevention of dementia or depression. As well, the guideline does not specifically address mild cognitive impairment.

Guideline Category

Diagnosis

Evaluation

Management

Risk Assessment

Screening

Treatment

Clinical Specialty

Geriatrics

Nursing

Psychiatry

Intended Users

Advanced Practice Nurses

Health Care Providers

Nurses

Guideline Objective(s)

To enhance the quality of practice pertaining to delirium, dementia, and depression in older adults, ultimately optimizing clinical outcomes through the use of evidence-based practices

Target Population

Older adults with delirium, dementia and/or depression

Note: For the purpose of the systematic review database searches for the guideline, the Registered Nurses' Association of Ontario (RNAO) applied the limiting term "adults age 65 years and older." When the term older adult is used within the guideline, however, it may refer to people younger than 65 who have aged prematurely or who have a shortened life expectancy due to factors such as the social determinants of health or chronic disease. Therefore, this Guideline may also apply to some individuals younger than 65 years of age.

Interventions and Practices Considered

1. Establishing therapeutic relationships
2. Identification and differentiation of signs and risk factors of delirium, dementia, and depression
3. Assessment of signs and symptoms on initial contact and when behavioral, mood, or cognitive changes are encountered
4. Identification of underlying causes of delirium and dementia
5. Assessment of physical, functional, and psychological status in patient with or at risk for dementia
6. Development and implementation of plan of care, including prevention of delirium, assessment and management of pain in patients with dementia, and pharmacological and non-pharmacological treatment of depression
7. Education and support of patient and family/caregivers
8. Monitoring and evaluation of treatment plans
9. Nursing education strategies directed at the competencies required for practice
10. Organization and policy strategies directed at practice settings and the environment in order to facilitate nurses' practice

Major Outcomes Considered

- Morbidity
- Mortality
- Quality of life
- Incidence and prevalence of dementia, delirium, and depression
- Length of stay in hospital
- Change in cognitive impairment
- Psychosocial outcomes in caregivers (e.g., caregiver distress, stress, depression, etc.)
- Suicidal ideation/risk

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Searches of Unpublished Data

Description of Methods Used to Collect/Select the Evidence

Guideline Review

The Registered Nurses' Association of Ontario (RNAO) guideline development team's project coordinator searched an established list of Web sites for guidelines and other relevant content published between January 2009 and March 2015. The resulting list was compiled based on knowledge of evidence-based practice Web sites and recommendations from the literature. Furthermore, expert panel members were asked to suggest additional guidelines.

Systematic Review

A comprehensive search strategy was developed by RNAO's research team and a health sciences librarian, based on inclusion and exclusion criteria created with the RNAO expert panel. A search for relevant articles published in English between October 2009 and April 2015 was applied to the following databases: Cumulative Index to Nursing and Allied Health (CINAHL), MEDLINE, MEDLINE In Process, Cochrane Library (Cochrane Database of Systematic Reviews and Cochrane Central Register of Controlled Trials), EMBASE, and PsycINFO; Education Resources Information Center (ERIC) was used for question three only. In addition to this systematic search, panel members were asked to review personal libraries for key articles not found through the above search strategies.

Detailed information about the search strategy for the systematic review, including the inclusion and exclusion criteria as well as search terms, is available in the guideline search strategy document (see the "Availability of Companion Documents" field).

Once articles were retrieved, two RNAO nursing research associates (nurses holding master's degrees) independently assessed the eligibility of the studies according to established inclusion/exclusion criteria. Any disagreements at this stage were resolved through tie-breaking by the project manager.

Hand Search

Panel members were asked to review personal libraries to identify key articles not found through the above search strategies. Articles identified by panel members were included in the search results if two nursing research associates independently determined the articles had not been identified by the literature search and met the inclusion criteria.

Number of Source Documents

Seventeen guidelines and 101 studies were selected to inform the recommendations and discussions of evidence. See the flow diagrams in Appendix C in the original guideline document for more information on the review process and the bibliography of all included studies (see the "Availability of Companion Documents" field).

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Levels of Evidence

Ia Evidence obtained from meta-analysis or systematic reviews of randomized controlled trials, and/or synthesis of multiple studies primarily of

quantitative research.

Ib Evidence obtained from at least one randomized controlled trial.

IIa Evidence obtained from at least one well-designed controlled study without randomization.

IIb Evidence obtained from at least one other type of well-designed quasi-experimental study, without randomization.

III Synthesis of multiple studies primarily of qualitative research.

IV Evidence obtained from well-designed non-experimental observational studies, such as analytical studies or descriptive studies, and/or qualitative studies.

V Evidence obtained from expert opinion or committee reports, and/or clinical experiences of respected authorities.

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Guideline Review

The Best Practice Guideline (BPG) program manager and nursing research associates appraised 21 international guidelines using the *Appraisal of Guidelines for Research and Evaluation Instrument II* (Brouwers et al., 2010).

Systematic Review

Quality appraisal scores for 24 articles (a random sample of approximately 20 percent of the total articles eligible for data extraction and quality appraisal) were independently assessed by Registered Nurses' Association of Ontario (RNAO) nursing research associates. Quality appraisal was assessed using AMSTAR (A Measurement Tool to Assess Systematic Reviews; see http://amstar.ca/index.php) and RNAO's scoring system that rates reviews as weak, moderate, or strong, depending on their quality scores. The nursing research associates reached acceptable inter-rater agreement (kappa statistic, κ=0.81), which justified proceeding with quality appraisal and data extraction for the remaining studies. The remaining studies were divided equally between the two research associates for quality appraisal and data extraction. A final narrative summary of literature findings was completed. The comprehensive data tables and narrative summary were provided to all expert panel members for review and discussion.

A complete bibliography of all full text articles screened for inclusion is available (see the "Availability of Companion Documents" field).

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Guideline Development Process

For this guideline, Registered Nurses' Association of Ontario (RNAO) assembled a panel of experts who represent a range of sectors and practice areas (see the "Composition of the Group That Authored the Guideline" field). A systematic review of the evidence was based on the purpose and scope, and was supported by the four research questions listed below. The systematic review captured relevant peer-reviewed literature and guidelines published between January 2009 and March 2015.The following research questions were established to guide the systematic review:

1. What are the most effective ways for nurses to screen or assess older adults for delirium, dementia, and depression?
2. What are the most effective approaches for management of older adults with delirium, dementia, and depression?
3. What education and training strategies (taught in basic curricula, advanced practice education or ongoing professional development

programs) do nurses need to be effective during the assessment and management of older adults with delirium, dementia, and/or depression?
4. What organizational policies and structures are required to enable nurses to assess and manage older adults with delirium, dementia, and/or depression?

This guideline is the result of the RNAO guideline development team and expert panel's work to integrate the most current and best evidence, and ensure the validity, appropriateness, and safety of the guideline recommendations with supporting evidence and/or expert panel consensus.

Rating Scheme for the Strength of the Recommendations

Not applicable

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

Stakeholder reviewers for the Registered Nurses' Association of Ontario (RNAO) guidelines are identified in two ways. First, stakeholders are recruited through a public call issued on the RNAO Web site (http://rnao.ca/bpg/get-involved/stakeholder). Second, key individuals and organizations with expertise in the guideline topic area are identified by the RNAO guideline development team and expert panel and are directly invited to participate in the review.

Reviewers are asked to read a full draft of the guideline and participate in the review prior to its publication. Stakeholder feedback is submitted online by completing a survey questionnaire. The stakeholders are asked the following questions about each recommendation:

- Is this recommendation clear?
- Do you agree with this recommendation?
- Is the discussion of evidence thorough and does the evidence support the recommendation?

The survey also provides an opportunity to include comments and feedback for each section of the guideline.

Survey submissions are compiled and feedback is summarized by the RNAO guideline development team. The RNAO development team and expert panel review and consider all feedback and, if necessary, modify the guideline content and recommendations prior to publication to address the feedback received.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified for each recommendation (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

- Early recognition of delirium, dementia, and/or depression can lead to timely structured assessments, diagnosis, treatment, and care.
- A meta-analysis, rated strong in methodological quality, reported that multi-component interventions to prevent delirium caused a relative reduction of 30 percent in incident delirium (i.e., delirium that develops while a person is hospitalized). In addition to preventing delirium, multi-component, non-pharmacological interventions have been found to prevent falls, to potentially help reduce the length of stay for those in acute care, and may help avoid institutionalization.
- Effective communication enhances positive behaviour, promotes more satisfying interactions, and improves overall quality of life for a person with dementia. Effective communication has also been shown to reduce agitation and responsive behaviours in persons with dementia and promote the person's dignity and sense of control.
- Cognitive interventions can be described as activities that teach new ways of carrying out cognitive tasks, and strategies to improve functioning or restore abilities in specific domains.
- Although most of the evidence is methodologically weak, one strong systematic review and meta-analysis of randomized controlled trials found that educational interventions for caregivers in the community decreased caregiver burden and depression. Other potential benefits may include reduced caregiver depression, reduced caregiver burden, enhanced caregiver well-being, improved quality of life, improved knowledge, improved coping skills or the ability to manage symptoms of dementia, and enhanced interactions with the person with dementia.
- Table 2 in the original guideline document lists benefits of non-pharmacological approaches to management of the behavioural and psychological symptoms of dementia (BPSD).

Potential Harms

The guideline points out the following potential harms associated with certain medications and the use of restraints:

- Medications (e.g., psychoactive medications and sedative-hypnotics) and polypharmacy contribute to an increased risk of delirium; they may also prolong delirium or cause excessive sedation. An increased risk exists when the medications are used with frail, older adults.
- Some medications (e.g., steroids) may be associated with major depression.
- One research group found that although antipsychotic and sedating medications may reduce agitation and behavioural symptoms, it is possible that the use of these medications may prolong delirium or convert hyperactive delirium into hypoactive delirium.
- Among people with depression who are at risk for suicide, potential drug interactions and toxicity in overdose of antidepressants and/or other medications should be considered, and the amount of drugs available limited (as required).
- In general, antipsychotic medications may increase the risk of adverse effects—for example, cerebrovascular events and death.
- Physical restraints are associated with an increased risk of delirium.

Qualifying Statements

Qualifying Statements

- These guidelines are not binding for nurses or the organizations that employ them. The use of these guidelines should be flexible based on individual needs and local circumstances. They neither constitute a liability nor discharge from liability. While every effort has been made to ensure the accuracy of the contents at the time of publication, neither the authors nor the Registered Nurses' Association of Ontario (RNAO) give any guarantee as to the accuracy of the information contained in them nor accept any liability, with respect to loss, damage, injury or expense arising from any such errors or omission in the contents of this work.
- This nursing Best Practice Guideline (BPG) is a comprehensive document that provides resources for evidence-based nursing practice. It is not intended to be a manual or "how to" guide, but rather a tool to guide best practices and enhance decision-making for nurses and other health-care providers working with older adults who have delirium, dementia, and/or depression. The guideline should be reviewed and applied in accordance with both the needs of individual organizations or practice settings and the needs and preferences of persons and their families accessing the health system for care and services. In addition, the guideline offers an overview of appropriate structures and supports for providing the best possible evidence-based care.

Implementation of the Guideline

Description of Implementation Strategy

Description of Implementation Strategy

Implementing guidelines at the point of care is multi-faceted and challenging; it takes more than awareness and distribution of guidelines for practice to change. Guidelines must be adapted for each practice setting in a systematic and participatory way, to ensure recommendations fit the local context. The Registered Nurses' Association of Ontario (RNAO) *Toolkit: Implementation of Best Practice Guidelines* (2nd ed.; 2012) provides an evidence-informed process for doing this (see Appendix L in the original guideline document).

The *Toolkit* is based on emerging evidence that successful uptake of best practice in health care is more likely when:

- Leaders at all levels are committed to supporting guideline implementation
- Guidelines are selected for implementation through a systematic, participatory process
- Stakeholders for whom the guidelines are relevant are identified and engaged in the implementation
- Environmental readiness for implementing guidelines is assessed
- The guideline is tailored to the local context
- Barriers and facilitators to using the guideline are assessed and addressed
- Interventions to promote use of the guideline are selected
- Use of the guideline is systematically monitored and sustained
- Evaluation of the guideline's impact is embedded in the process
- There are adequate resources to complete all aspects of the implementation

The *Toolkit* uses the "Knowledge-to-Action" framework to demonstrate the process steps required for knowledge inquiry and synthesis. It also guides the adaptation of the new knowledge to the local context and implementation. This framework suggests identifying and using knowledge tools, such as guidelines, to identify gaps and to begin the process of tailoring the new knowledge to local settings.

RNAO is committed to widespread deployment and implementation of the Best Practice Guidelines (BPGs). The RNAO uses a coordinated approach to dissemination, incorporating a variety of strategies, including:

1. The Nursing Best Practice Champion Network®, which develops the capacity of individual nurses to foster awareness, engagement, and adoption of BPGs
2. Nursing order sets, which provide clear, concise, actionable intervention statements derived from the BPGs' practice recommendations that can be readily embedded within electronic medical records, but may also be used in paper-based or hybrid environments
3. The Best Practice Spotlight Organization® (BPSO®) designation, which supports implementation at the organization and system levels. BPSOs® focus on developing evidence-based cultures with the specific mandate to implement, evaluate, and sustain multiple RNAO BPGs

In addition, the RNAO offers capacity-building learning institutes on specific BPGs and their implementation annually.

Information about RNAO implementation strategies can be found at:

- RNAO Best Practice Champions Network®: http://rnao.ca/bpg/get-involved/champions
- RNAO Nursing Order Sets: http://rnao.ca/ehealth/nursingordersets
- RNAO Best Practice Spotlight Organizations®: http://rnao.ca/bpg/bpso
- RNAO capacity-building learning institutes and other professional development opportunities: http://rnao.ca/events .

Implementation Tools

Audit Criteria/Indicators

Clinical Algorithm

Mobile Device Resources

Resources

Tool Kits

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Safety

Timeliness

Identifying Information and Availability

Bibliographic Source(s)

Registered Nurses' Association of Ontario (RNAO). Delirium, dementia, and depression in older adults: assessment and care. Toronto (ON): Registered Nurses' Association of Ontario (RNAO); 2016 Jul. 156 p. [184 references]

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2016 Jul

Guideline Developer(s)

Registered Nurses' Association of Ontario - Professional Association

Source(s) of Funding

Funding was provided by the Ontario Ministry of Health and Long-Term Care.

Guideline Committee

Registered Nurses' Association of Ontario Expert Panel

Composition of Group That Authored the Guideline

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Financial Disclosures/Conflicts of Interest

Declarations of interest that might be construed as constituting an actual, potential, or apparent conflict were made by all members of the Registered Nurses' Association of Ontario (RNAO) expert panel, and members were asked to update their disclosures throughout the guideline development process. Information was requested about financial, intellectual, personal, and other interests and documented for future reference. No limiting conflicts were identified.

Further details are available from the RNAO.

Guideline Status

This is the current release of the guideline.

This guideline updates previous versions: Registered Nurses' Association of Ontario (RNAO). Screening for delirium, dementia and depression in older adults 2010 supplement. Toronto (ON): Registered Nurses' Association of Ontario (RNAO); 2010 May. 24 p. [76 references]

Registered Nurses' Association of Ontario (RNAO). Screening for delirium, dementia and depression in older adults. Toronto (ON): Registered Nurses' Association of Ontario (RNAO); 2003 Nov. 88 p. [53 references]

Registered Nurses' Association of Ontario (RNAO). Caregiving strategies for older adults with delirium, dementia and depression 2010 supplement. Toronto (ON): Registered Nurses' Association of Ontario (RNAO); 2010 May. 36 p. [174 references]

Registered Nurses' Association of Ontario (RNAO). Caregiving strategies for older adults with delirium, dementia and depression. Toronto (ON): Registered Nurses' Association of Ontario (RNAO); 2004 Jun. 181 p. [247 references]

This guideline meets NGC's 2013 (revised) inclusion criteria.

Guideline Availability

Available from the Registered Nurses' Association of Ontario (RNAO) Web site.

Availability of Companion Documents

The following are available:

- Registered Nurses' Association of Ontario – Nursing Best Practice Guidelines Program: delirium, dementia, and depression in older adults. Systematic review search strategy. Toronto (ON): Registered Nurses Association of Ontario (RNAO); 2016. 4 p. Available from the Registered Nurses' Association of Ontario (RNAO) Web site.
- Registered Nurses' Association of Ontario – Nursing Best Practice Guidelines Program: delirium, dementia, and depression in older adults. Bibliography. Toronto (ON): Registered Nurses Association of Ontario (RNAO); 2016. 10 p. Available from the RNAO Web site.
- Declarations of interest. Toronto (ON): Registered Nurses Association of Ontario (RNAO); 2016. 5 p. Available from the RNAO Web site.
- RNAO delirium, dementia, and depression in older adults: assessment and care. Recommendation comparison chart. Toronto (ON): Registered Nurses Association of Ontario (RNAO); 2016 Jul. 8 p. Available from the RNAO Web site.
- Toolkit: implementation of best practice guidelines. Second edition. Toronto (ON): Registered Nurses' Association of Ontario (RNAO); 2012 Sep. 154 p. Available from the RNAO Web site.

Various tools, including descriptions of types of dementia; delirium risk factors and interventions; screening and assessment tools; early warning signs of cognitive change; and a table of attitudes, skills, and knowledge that are beneficial for communication in dementia care are available in the appendices of the original guideline document. Structure, process and outcome indicators for monitoring and evaluating the guideline are available in Table 10 in the original guideline document.

Mobile versions of RNAO guidelines are available from the RNAO Web site.

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI on November 3, 2004. The information was verified by the guideline developer on November 23, 2004. This summary was updated by ECRI Institute on July 8, 2011. The updated information was verified by the guideline developer on August 9, 2011. This summary was updated by ECRI Institute on October 17, 2016. The updated information was verified by the guideline developer on November 4, 2016.

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